

08892

CERTIFICATE OF DEATH

Reg. Dist. No. 08903

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Harrisburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75 x - 3</b> d. STREET ADDRESS <b>252 Liberty Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ippolito</b> First Middle Last <b>Alitto</b>		4. DATE OF DEATH Month Day Year <b>Aug. 27 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1872</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Storekeeper</b>	
11. BIRTHPLACE (State or foreign country) <b>Castiglione Cosentino</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Salvatore Alito</b>		14. MOTHER'S MAIDEN NAME <b>Marie Barbuslio</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Agustalitto Alitto</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-23</b> , 19 <b>57</b> , to <b>8-27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-27-57</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. E. W. Dethlefs</b> M.D. ADDRESS (Street, city or town, state) DATE SIGNED <b>8-27-57</b> PHYSICIAN'S NAME (Type) <b>Hagerstown Md</b> <b>Hagerstown Md</b> <b>8-27-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-30-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Harrisburg, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Poyser</b>		24a. REC'D BY REGISTRAR <b>Aug 29, 1957</b>	
ADDRESS <b>Hagerstown Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

AUG 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08904

08893

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 15242			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Emergency Room - Hospital</b>				d. STREET ADDRESS <b>1108 Old Dover Way</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Carleton</b> Last <b>Baer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1924</b>		9. AGE (In years last birthday) <b>33</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l Cash Register</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Donnie T. Baer</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Rae Baer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>191-18-9599</b>		17. INFORMANT <b>Joseph R. Baer-</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon-Monoxide Poisoning</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Connected hose from exhaust into automobile</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:00 AM Aug. 8 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural-Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Uniontown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Uniontown Fayette Co Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 12, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU OF

AUG 14 1957

RECEIVED

08942

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Boyle</u> Last <u>Boyle</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1870</u>
9. AGE (In years, last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James William Findlay</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Nancy Knowles</u> Address <u>ny, n.y. 200 E. 66 St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>54</u> , to <u>Aug 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>57</u> , and that death occurred at <u>12:30 a. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Patomas Street</u> DATE SIGNED <u>29 Aug 57</u>			
ACTUAL SIGNATURE <u>Paul Haak</u> M.D.		PHYSICIAN'S NAME (Type) <u>PAUL HAAS, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 29-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Wolf</u> ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>E. Lee M. Elroy</u> DATE <u>Aug 29, 57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. 3.

AUG 30 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Waynesboro.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro.</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>119 West 3rd St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Franklin</u> Last <u>Burger</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1872</u>
9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ASSISTANT MANAGER FREIGHT OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>Quincy Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gideon Burger</u>		14. MOTHER'S MAIDEN NAME <u>Lavina Manges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paul W. Burger - 119 W. 3rd St. Waynesboro, Pa.</u>	
17. INFORMANT <u>Paul W. Burger - 119 W. 3rd St. Waynesboro, Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 420.0 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 months</u> DUE TO (c) <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 27, 1957</u> to <u>Aug. 31, 1957</u> , that I last saw the deceased alive on <u>Aug. 31, 1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H. Hak</u>		DATE SIGNED <u>31 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Paul Hak M.D.</u>		ADDRESS (Street, city or town, state) <u>28 W. Paternoe St. Waynesboro, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/4/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PRICES CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO R.D. 2, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hare</u>		24a. REC'D BY REGISTRAR <u>Walter J. Hare</u>	
ADDRESS <u>Waynesboro, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Walter J. Hare</u>	

## ST. ANDREW'S - 10110 101 STREET, ST. ALBERT, AB T8N 6K6

SEP 9 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08907

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at home 128 S. Potomac Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>128 S. Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Augustus</b> Last <b>Burger</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1884</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Office Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Secretary Woodmen of World</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Augustus Burger</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Henrietta Rider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-7188</b>	
17. INFORMANT <b>Mrs. Anna B. Burger</b>		Address <b>128 S. Potomac St City</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>none</b> (c) <b>none</b> DUE TO (a), stating the underlying cause last, (c) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Aug. 30 '57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-3-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Norment</b>		ADDRESS <b>Hagerstown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Sept. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

SEP 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08908

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On Key St.</u>				d. STREET ADDRESS <u>401 Overbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT JACOB CANFIELD</u>				4. DATE OF DEATH Month Day Year <u>August 13 1957 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan'y 18 1918</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Glenn Martin Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Butte Silver Bow</u>		11. BIRTHPLACE (State or foreign country) <u>Montanna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert W. Canfield</u>				14. MOTHER'S MAIDEN NAME <u>Florence Hiatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W.2</u>		17. INFORMANT <u>Mrs Lili Canfield</u> Address <u>401 Overbrook Rd Baltimore Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>shot self thru heart with 22 calibre revolver</u>			
20c. TIME OF INJURY Month, Day, Year <u>8 - 13 1957</u> Hour min. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown</u>		20f. (City or town) (County) (State) <u>Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deposit Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deposit Broome Co New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Reg. 16-1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blanch Roovers</u>		DATE SIGNED <u>Aug-14-57</u>	

BUREAU V. E.

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Filed 21-11-16-57 et

08944

## CERTIFICATE OF DEATH

08909

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>" "</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Twin I</u> First <u>not</u> Middle <u>named</u> Last <u>Chaney</u>		4. DATE OF DEATH <u>Aug. 20</u> Month <u>20</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-57</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Christina Staley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(11 yrs. give year or dates of service)</u>		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 5 1/2 MO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 1/2 MO</u> DUE TO (c) <u>2 HR</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Shops</u> 19 <u>57</u> to <u>Shops</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Shops</u> 19 <u>57</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Aug 23/57</u>	
ACTUAL SIGNATURE <u>Carl E. Young</u> M.D.		PHYSICIAN'S NAME (Type) <u>William F. Young</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>✓</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>9/3/57</u>		<u>Chas. Bowers</u>	



BUREAU A

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3& Block 12 P. 12, 201 10-16-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08896  
08910  
202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wm. # 3, Pagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Miss. County Hospital</u>		e. STREET ADDRESS <u>King St</u>	
3. NAME OF DECEASED (Type or print) <u>Twin IL</u> First <u>Marie</u> Middle <u>Chaney</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-57</u>
9. AGE (In years last birthday) <u>5</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Kristina Staley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crematinity</u> 5 1/2 MO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/20/57</u> to <u>8/21/57</u> 19 <u>57</u> that I last saw the deceased alive on <u>8/21/57</u> and that death occurred at <u>1:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pagerstown, Maryland</u> DATE SIGNED <u>8/23/57</u> ACTUAL SIGNATURE <u>Ralph E. Young</u> PHYSICIAN'S NAME (Type) <u>William H. Young</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u></u>	22b. DATE THEREOF <u>?</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hospital disposal</u>	22d. LOCATION (City, town, or county) (State) <u>Pagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>9/3/57</u>		<u>Chas. Brown</u>	

RECEIVED

SEP 4 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08897

CERTIFICATE OF DEATH

08911

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C.</u>		d. STREET ADDRESS <u>1815 17th St. N. W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA ALICE COLLIER</u>		4. DATE OF DEATH Month Day Year <u>Aug. 26 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1 1914</u>
9. AGE (In years last birthday) yrs <u>42</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <u>11 25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov. Dept. Of Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Stoneham Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Collier</u>		14. MOTHER'S MAIDEN NAME <u>Ada Rose Brock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 10 3040</u>	
17. INFORMANT <u>Mrs. James Sachs</u>		Address <u>Funkstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). <u>Acute lobar pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Circulatory failure (shock)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/24, 1957</u> , to <u>8/26, 1957</u> , that I last saw the deceased alive on <u>8/26 1957</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>154 West Washington St.,</u>		DATE SIGNED <u>8:28:57</u>	
ACTUAL SIGNATURE <u>John H. Hornbaker</u>		M.D. <u>John H. Hornbaker, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter L. Leaf</u>		ADDRESS <u>Williamsport, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug. 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

U. S. V. 100

1967

DELA



08898

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08912

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>18 N. Carlisle St.</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>M.</u> Middle <u>COLLIER</u> Last		4. DATE OF DEATH <u>August 31</u> Month <u>1957</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1873</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Worker U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ed. Geo. W. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Ann Elizabeth Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (a) none) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Dail Hemminger</u> Address <u>37 W. Madison, Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute - Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>&amp; Congestive Failure</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>17 Aug</u> , 19 <u>57</u> to <u>30 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 Aug</u> , 19 <u>57</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Greencastle</u>		DATE SIGNED <u>12</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL - CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Minnich</u>		24a. REC'D BY REGISTRAR <u>Aug. 31, 1957</u>	
ADDRESS <u>Greencastle, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

SAU V. M.

57

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08899

## CERTIFICATE OF DEATH

08913  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY in 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Maryland RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Antietam</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>R</u> Last <u>Crampton</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1910</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Assembly</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Fairchild's</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Harvey Crampton</u>				14. MOTHER'S MAIDEN NAME <u>Grace Viola Boyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-3587</u>		17. INFORMANT <u>Mrs. Hattie Crampton</u> Address <u>Antietam Md RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause unknown.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18 )					
20c. TIME OF INJURY Month. <u>8</u> Day. <u>12</u> Year <u>19 57</u> Hour a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>8/12/57</u> , 19 <u>57</u> , to <u>8/13/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/12/57</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u>				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>		DATE SIGNED <u>8/14/57.</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lee</u>				ADDRESS <u>Williamport, Maryland</u>		24a. REC'D BY REGISTRAR <u>Aug. 17 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Charles H. Brown</u>

BUREAU V. S.

MAR 20 1957

RECEIVED

08910

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>318 South Potomac Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Gregory</b> Middle <b>Allen</b> Last <b>Delouney</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 16, 1957</b>	
9. AGE (In years last birthday) <b>4</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Charles Delouney</b>			
14. MOTHER'S MAIDEN NAME <b>Betty Jane Kelly</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Mr. Charles Delouney</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hilcer Membrane Disease</b> DUE TO <b>4 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Prematurity</b> (c) <b>Prematurity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>August</b> Day <b>19</b> Year <b>1957</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Washington</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>8/16/57</b> 19 to <b>8/20/57</b> 19, that I last saw the deceased alive on <b>8/20/57</b> 19, and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>SEARL YOUNG M.D.</b>				DATE SIGNED <b>8/24/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>				22e. (State) <b>Maryland</b>		22f. (County) <b>Washington</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				23a. ADDRESS <b>Hagerstown, Maryland</b>		23b. REC'D BY REGISTRAR <b>Aug. 24, 1957</b>	
23c. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>				23d. (City, town, or county) <b>Hagerstown, Maryland</b>		23e. (State) <b>Maryland</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU Y. S.

AUG 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08915

301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 7 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 129 E. Potomac Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md. RFD X/	
3. NAME OF (Type or print) Mr. Benjamin Roy Dewey		d. STREET ADDRESS Hopewell Road	
4. DATE OF DEATH Aug. 26 19 57		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 2 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Quincy Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Lum Dewey		14. MOTHER'S MAIDEN NAME Susan Harshman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30 9939	
17. INFORMANT Mrs. Frances Dewey		Address Hopewell Road Williamsport Md RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-1 DUE TO Acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None 20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Aug. 27 '57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29-57	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

BUREAU V. E.

AUG 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
08911  
CERTIFICATE OF DEATH

08916

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>PENNA</u> b. COUNTY <u>Fulton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haverstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AMARANTH</u> <u>75</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp</u>				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DWANE</u> <u>DERRICK</u> <u>DIEHL</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>2</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/57</u>		9. AGE (In years last birthday) <u>—</u> yrs. <u>2</u> Months <u>3</u> Days <u>—</u> Hours <u>—</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs WVA</u>	
13. FATHER'S NAME <u>Allen Crown Diehl</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO —		17. INFORMANT Address <u>Allen C. Diehl Amaranth Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Disease (Transposition of the</u> DUE TO (c) <u>great vessel</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>—</u> <u>—</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/26</u> , 1957, to <u>8/2</u> , 1957, that I last saw the deceased alive on <u>8/1</u> , 1957, and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Young</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>302 N Potomac St.</u> <u>8/2/57</u>			
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				<u>Haverstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 4 1957</u>		<u>Whips Cove Cem</u>		<u>AMARANTH PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. M. Sipes Harrisonville Pa</u>				24a. REC'D BY REGISTRAR <u>Aug 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

RECEIVED

AUG 7 1957

BUREAU V. \*



08922

CERTIFICATE OF DEATH

Reg. Dist. No.

089172

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN TB <b>MINUTES</b>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>WASH.CO.HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X ROHRERSVILLE</b>			
				d. STREET ADDRESS <b>MAIN STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>M</b> Last <b>EASTON</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1957</b> 19			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 7 1884</b>		9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ROHRERSVILLE WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MILLARD CLOPPER</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN HUFFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>MISS GLADYS EASTON ROHRERSVILLE MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 hr.</b> <b>10 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 15, 1950</b> to <b>Aug. 15, 1957</b> , that I last saw the deceased alive on <b>July 20, 1957</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Md.</b> DATE SIGNED <b>8/16/57</b>							
ACTUAL SIGNATURE <b>B. B. Kneisley</b>				M D <b>148 West Washington St. Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M. D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 17 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROHRERSVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ROHRERSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home</b> ADDRESS <b>Bowlesville Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Beach H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
AUG 22 1957  
BUREAU V. R.

## CERTIFICATE OF DEATH

Dr J. H. Kehne

Reg. Dist. N302

08903

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>7 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash. County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>107 Clinton Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DELLA MAE EMMERT</b>		4. DATE OF DEATH Month Day Year <b>August 3 1957 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7 1891</b> 9. AGE (In years last birthday) <b>66</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Beachley-Reichard Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairplay Wash. Co Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>William Emmert</b>		14. MOTHER'S MAIDEN NAME <b>Ida Sheeley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-9513</b>	
17. INFORMANT <b>Mrs Mary E. Renner</b>		Address <b>107 Clinton Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE INTESTINAL OBSTRUCTION</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ADENOCARCINOMA LEFT COLON RECURRENT</b> DUE TO (c) <b>8 WEEKS</b> <b>2 1/2 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 WEEKS</b> <b>2 1/2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>153X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 16</b> , 19 <b>57</b> , to <b>AUGUST 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>AUGUST 2</b> , 19 <b>57</b> , and that death occurred at <b>10:08 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>131 W. WASHINGTON ST.</b> DATE SIGNED <b>8/3/57</b> ACTUAL SIGNATURE <b>John H. Kehne</b> M.D. PHYSICIAN'S NAME (Type) <b>JOHN H. KEHNE M.D.</b> <b>HAGERSTOWN, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/4/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. REC'D BY REGISTRAR <b>Aug 6 1957</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wheat Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

AUG 8 1957

RECEIVED

08946

CERTIFICATE OF DEATH

Reg. Dist. No.

08919  
20

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY in 1b <u>2 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEM. HOME</u>				e. STREET ADDRESS <u>FAHRNEY-KEEDY MEM. HOME</u>			
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>E.</u> Last <u>ENGLER</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 13-1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER-BRETHREN CHURCH</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>SOLOMON P. ENGLER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ROOP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MARIANNA ENGLER - F.K. MEM. HOME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 18, 1957</u> to <u>August 18, 1957</u> , that I last saw the deceased alive on <u>August 18, 1957</u> , and that death occurred at <u>Boonsboro, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Lelan</u> M.D.				DATE SIGNED <u>8/18/57</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Lelan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley &amp; Sons, New Windsor, Md.</u>				24a. REC'D BY REGISTRAR <u>22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Brady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 22 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		d. STREET ADDRESS <b>219 Colonial Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>CRAWFORD</b> Last <b>ESTERLINE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 26, 1875</b>
9. AGE (n years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Anderson, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Esterline</b>		14. MOTHER'S MAIDEN NAME <b>Annie Crawford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Jane Etchison</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sarcoma of the lung with metastasis</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Altoona,</b>		(County) <b>Pennsylvania</b> (State)	
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>57</b> , to <b>Aug. 30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 30</b> , 19 <b>57</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington Street</b> DATE SIGNED <b>8/30/57</b> ACTUAL SIGNATURE <b>B. B. Kneisley</b> M.D. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b> <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/2/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Altoona, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>G. J. Suter-Rouzer</b>		ADDRESS <b>Hagerstown, Md.</b>	24. RECEIVED BY REGISTRAR <b>Sept. 5, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. T. Weaver</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 9 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08921

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>37 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>128 Ross St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Fair</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR: Months <b>03</b> Days <b>03</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city government</b>	
11. BIRTHPLACE (State or foreign country) <b>Taneytown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Fair</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Schriver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-09-2449</b>	
17. INFORMANT <b>Mary L. Fair, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Coronary artery disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-20-57</b> 19 <b>57</b> , to <b>2-25</b> 19 <b>57</b> , that I last saw the deceased alive on <b>2-24-57</b> 19 <b>57</b> , and that death occurred at <b>5:45</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. W. L. Smith</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. W. L. Smith</b>		DATE SIGNED <b>2-25-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-27-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Reg. 29-1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

OFFICE OF THE  
ATTORNEY GENERAL

1957

DEPT. OF JUSTICE

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>444 West Franklin St</u>				d. STREET ADDRESS <u>444 West Franklin St</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ELIZABETH</u> Last <u>FOX</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1957</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7 1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Clear Spring Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Werdebaugh</u>				14. MOTHER'S MAIDEN NAME <u>Rosanne Whetstone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Alpha Grove 444 W. Franklin st</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary artery disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>at 13 - 1957</u> to <u>Aug 20 - 1957</u> , that I last saw the deceased alive on <u>Aug 19 - 57</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Andrew K. Coffman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. F. W. J. J. J. J.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Powers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUG 27 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN TB <b>D.O.A.</b>				d. STREET ADDRESS <b>238 Jefferson Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Danny</b> Middle <b>Fratianni</b> Last <b>Fratianni</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1934</b>	
9. AGE (In years last birthday) <b>23 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>12</b>		IF UNDER 24 HRS Hours <b>12</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Horse Race Stable</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Angelo Fratianni</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Robucci</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-30-2867</b>		17. INFORMANT <b>Mr. Angelo Fratianni</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>422d</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stoker-Adams Syndrome</b> DUE TO (c) <b>Myocardial fibrosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Undetermined</b> <b>Undetermined</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a m</b> Month <b>19</b> Day <b>19</b> Year <b>1957</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>145 W. Washington</b>	
20f. (City or town) <b>Hagerstown, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>July 8, 1957</b> , to <b>Aug 1, 1957</b> , that I last saw the deceased alive on <b>Aug 1, 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W. Washington</b> DATE SIGNED <b>8/2/57</b> ACTUAL SIGNATURE <b>L. L. Packer Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>L. L. Packer Jr.</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/5/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Roper</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 3, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Phyllis Gowers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

16 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Louisiana</b> b. COUNTY <b>Orleans</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Orleans</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Enroute to Washington County Hospital</b>				d. STREET ADDRESS <b>2010 Palmer Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>Eldridge</b> Last <b>Gillis</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1902</b>		9. AGE (in years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b>55</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Poydras Plantation La.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gary Gillis</b>				14. MOTHER'S MAIDEN NAME <b>Stella Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Carlotta Gillis New Orleans La.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year How a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Metairie Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Orleans La.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 3, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Barth H. Bowers</b>	

MEDICAL CERTIFICATION

RECEIVED

SEP 5 1957

BUREAU V. S.



## 08925

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] Page 1 may be returned by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, [redacted] Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 19 1957

BUREAU V. 3

## CERTIFICATE OF DEATH

08926

Reg. Dist. No. 302

08910

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>247 Summit Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Worth</b> Middle <b>Harne</b> Last <b>Harne</b>		4. DATE OF DEATH Month <b>8</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1866</b>
9. AGE (In years last birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Danzer Metal Wks</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Harne</b>		14. MOTHER'S MAIDEN NAME <b>Mary Meredith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-09-9971</b>	
17. INFORMANT <b>Mrs. Charles Kitzmiller</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>400.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 57</b> , 19 <b>57</b> , to <b>Aug 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 7</b> , 19 <b>57</b> , and that death occurred at <b>10:45 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W Washington St</b> DATE SIGNED <b>8/10/57</b> ACTUAL SIGNATURE <b>Robert Vh Campbell</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert Vh Campbell</b> <b>Hagerstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>8-12-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be defined for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 15 1957

BUREAU V. M.

08947

## CERTIFICATE OF DEATH

08927

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Hagerstown RD6 (State Line)</b>		e. STREET ADDRESS <b>Hagerstown RD6 (State Line)</b>	
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>ELIZABETH</b> Last <b>HARTLE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 23, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>H. ome</b>	
11. BIRTHPLACE (State or foreign country) <b>State Line</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Barnhart</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Ann Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Stanley W. Hartle</b>		Address <b>Hag. RD6 (State Line)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR Collapse</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE Cardiovascular Di</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> <b>hrs.</b> <b>yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 20, 1957</b> to <b>Aug 20, 1957</b> , that I last saw the deceased alive on <b>Aug 20, 1957</b> , and that death occurred at <b>10 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1195 Antietam St. Hagerstown, Md.</b> DATE SIGNED <b>P-20-57</b>			
ACTUAL SIGNATURE <b>Louis G. Graff</b>		M.D. <b>1195 Antietam St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF M.D. Hagerstown</b>		<b>P-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/23/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Beautiful View</b>	22d. LOCATION (City, town, or county) (State) <b>Washington Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A.E. Minnich</b>		ADDRESS <b>Greencastle, Penna.</b>	24a. REC'D BY REGISTRAR <b>Aug 20, 1957</b>
24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 22 1957

BUREAU V. B.

08948

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>			
c. LENGTH OF STAY IN 1b <u>82 yrs.</u>				d. STREET ADDRESS <u>14 Conococheague St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Conococheague St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertie IMO Hawken</u>				4. DATE OF DEATH Month Day Year <u>Aug. 31 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>8 30</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>William Oscar Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Ardinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mr. Richard G. Hawken Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>174 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>830</u>	
20f. (City or town) <u>Williamsport</u>				20g. (County) <u>Maryland</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>2/28/57</u> 19 <u>57</u> to <u>8/31/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8/31/57</u> and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>Williamsport Md.</u> DATE SIGNED <u>8/31/57</u>							
ACTUAL SIGNATURE <u>Ralph Young</u>							
PHYSICIAN'S NAME (Type) <u>Albert L. Williamsport Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williamsport Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. C. Brown</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1957

BUREAU V. S.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00911

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. STREET ADDRESS <u>Edgemont Road</u>	
3. NAME OF DECEASED (Type or print) First <u>DORIS</u> Middle <u>FAY</u> Last <u>HORST</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28 1957</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>	
11c. BIRTHPLACE (State or foreign country) <u>Md. Hagerstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David K. Horst</u>		14. MOTHER'S MAIDEN NAME <u>Arlene Whitmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>David K. Horst</u>		Address <u>Smithsburg R#2 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity and pulmonary atelectasis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug. 28</u> , 19 <u>57</u> , to <u>Aug. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 28</u> , 19 <u>57</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ M.D. <u>148 West Washington Street</u> <u>8/28/57</u> ACTUAL SIGNATURE <u>B. B. Kneisley</u> PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wetlys Cemetery near Greensburg Wash Co Md.</u>	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Bowers</u>	

2001 XV2

RECEIVED

1957

MAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08930

Reg. Dist. No.

08949

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural R # 1</b>				d. STREET ADDRESS <b>Rural R # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Thomas</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1884</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apple orchards</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Caroline V. Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>World I</b>		16. SOCIAL SECURITY NO. <b>214-16-1756</b>		17. INFORMANT Address <b>Wm. Douglas Johnson, Baltimore, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound ( 12 gauge shot gun) into chest and region of heart -hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Shot self in lt chest with 12 gauge shot gun</b>					
20c. TIME OF INJURY Month, Day, Year <b>10:00 AM Aug. 2 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		20f. (City or town) (County) (State) <b>Knoxville Rural Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Lee Fazio</b>				24a. REC'D DATE <b>AUG 7 '57</b>			

*Deed*

BUREAU V. S.

AUG 7 1957

RECEIVED

W. J. B. B.

08912

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES RUSH KEADLE</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 10 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 21 1871</b>		9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>NR. BOONSBORO WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN E. KEADLE</b>				14. MOTHER'S MAIDEN NAME <b>HELEN FORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>CHARLES K. KEADLE BOONSBORO MD. ROUTE 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>100.1 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>Uncomplicated arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>5 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 7, 1957</b> to <b>Aug 10, 1957</b> , that I last saw the deceased alive on <b>August 9, 1957</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> DATE SIGNED <b>8/11/57</b>							
ACTUAL SIGNATURE <b>G. W. L. E. Van</b>				PHYSICIAN'S NAME (Type) <b>G. W. L. E. Van</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 12 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonsboro Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 14, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 19 1957

BUREAU V. S.

08913

Item 1 Film 6219 8-14-57 at  
**CERTIFICATE OF DEATH**

08932

Reg. Dist. No. 304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Md.</u> <b>Washington</b> <b>County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Died inroute to Hospital</u>		d. STREET ADDRESS <u>255 W. Main St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Howard</u> Last <u>Keefer</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.20.1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman B&amp;O R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin V.B. Keefer</u>		14. MOTHER'S MAIDEN NAME <u>Sally Keefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>705-05-9268</u>	
17. INFORMANT <u>Mrs Geneva B Keefer</u>		Address <u>Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 Mesenteric Thrombosis</u> DUE TO <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unknown</u> DUE TO (c) <u>6 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 2, 1957</u> to <u>Aug 2, 1957</u> that I last saw the deceased alive on <u>Aug 2, 1957</u> and that death occurred of <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. M. Shaffer</u> M.D.		ADDRESS (Street, city or town, state) <u>Hancock Md.</u> DATE SIGNED <u>8/3/57</u>	
PHYSICIAN'S NAME (Type) <u>L. M. SHAFFER</u>		HANCOCCK MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8.6.57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>		ADDRESS <u>Hancock Md.</u> DATE <u>8/6/57</u> <u>G. Keller</u>	

RECEIVED

AUG 8 1957

BUREAU V. S.



08814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>R D #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Debra</b> Middle <b>Marie</b> Last <b>Kidwell</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1955</b>		9. AGE (In years last birthday) <b>2 yrs</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b>	IF UNDER 24 HRS Hours <b>11</b> Min <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>Berkeley Springs, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Leo Kidwell</b>				14. MOTHER'S MAIDEN NAME <b>Geraldine Decker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Robert Leo Kidwell, Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuroblastoma, with</b> <b>175X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last } (b) <b>generalized metastasis to skull,</b> DUE TO (c) <b>long bones + mediastinum</b>						INTERVAL BETWEEN ONSET AND DEATH <b>about 6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia severe</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/20/</b> 19 <b>57</b> , to <b>8/23/</b> 19 <b>57</b> , that I last saw the deceased alive on <b>8/23/</b> 19 <b>57</b> , and that death occurred at <b>9:30</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. M. Bacon Jr</b>				DATE SIGNED <b>302 N. Patomac St. Hagerstown Md. 9/1/57</b>			
PHYSICIAN'S NAME (Type) <b>A. M. Bacon Jr</b>				ADDRESS <b>302 N. Patomac St, Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Great Cacapon Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Great Cacapon, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PARKS FUNERAL HOME</b>				ADDRESS <b>Berkeley Spgs, W. Va.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

SEP 16 1957

RECEIVED

08950

CERTIFICATE OF DEATH

08933

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laerstown, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside League Nursing Home</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>Benjamin</u> Last <u>Landers</u>		4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>11</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Landers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mendenall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-03-9455</u>	
17. INFORMANT <u>Mrs. Pearl Jaddie Rural 1 Hancock, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 15, 1957</u> to <u>Aug. 11, 1957</u> , that I last saw the deceased alive on <u>Aug. 10, 1957</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Clear Spring Md</u> <u>8/13/57</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Shore Hancock Md</u>		24a. REC'D BY REGISTRAR <u>Leroy M. Fickler</u>	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 24 1957

BUREAU V. 8

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08915

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08934

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>H</b> Last <b>Leaman</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1875</b>	9. AGE (In years last b. rthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bookbinder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Leaman</b>				14. MOTHER'S MAIDEN NAME <b>Jabe Eversfield Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-28-8790</b>		17. INFORMANT <b>Claude H. Leaman</b>			Address <b>17 East Ave. Hagerstown, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fracture ribs</b> <b>812X</b> DUE TO <b>Fracture pelvis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage and shock</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b> <b>3 1/2 hrs</b> <b>3 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hit by truck while crossing street</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:10 P.M. 8-5-19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Hagerstown</b>	(County) <b>Washington</b>	(State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-6-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>August 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 7, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

BUREAU V. E.

AUG 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08935  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>35 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Washington County Hospital</b>				d. STREET ADDRESS <b>822 Woodland Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Cronise</b> Last <b>Lease</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 21, 1992</b>		
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Implement Supply</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Machinery</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward C. Lease</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Cronise</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. #1 214-09-9702</b>		17. INFORMANT Address <b>822 Woodland Way</b> <b>Mrs. Margaret R. Lease - Hagerstown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> <b>443X</b> DUE TO Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (b) <b>8 yrs</b> (c) <b>8 yrs</b> DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 12, 1957</b>		
				24b. REGISTRAR'S SIGNATURE <b>W. J. Horment</b>				

BUREAU V. L.

1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 08917 CERTIFICATE OF DEATH

08936

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>25 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Warren Light Lettich</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>		11. BIRTHPLACE (State or foreign country) <b>Lebanon Penn.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Lettich</b>				14. MOTHER'S MAIDEN NAME <b>Emma Light</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>214-09-2137</b>		17. INFORMANT <b>Mrs. Ruth E. Lettich</b> Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency &amp; Heart Failure</b> DUE TO <b>Acute Cholelithiasis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 15</b> to <b>26 Aug. 1957</b> , that I last saw the deceased alive on <b>26 Aug. 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. D. Wilson</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>8/27/57</b>					
PHYSICIAN'S NAME (Type) <b>J. D. WILSON, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Annville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annville Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 29 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

BUREAU V. 3

3 1957

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**08918**  
**CERTIFICATE OF DEATH**

08937  
 Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>50 yrs.</b>				d. STREET ADDRESS <b>705 Orchard Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>LIDA</b> Middle <b>ELLA</b> Last <b>LINDSAY</b>		4. DATE OF DEATH		Month <b>August</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1897</b>	9. AGE (in years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John D. Higgs</b>				14. MOTHER'S MAIDEN NAME <b>Florence V. Ditto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. Geo. R. Lindsay</b> Address <b>705 Orchard Rd. Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular hypertension</b> <b>201X</b> DUE TO <b>Acute Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>27 yrs</b> <b>80 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Oct. 19 32</b> , to <b>Aug. 21 19 57</b> , that I last saw the deceased alive on <b>Aug. 19 19 57</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>		DATE SIGNED <b>8-21-57</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>				ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 22 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

*Wm. A. Host & Sons*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 23 1957

BUREAU V. S.

08919

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 58 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1226 Crescent Road		d. STREET ADDRESS 1226 Crescent Road	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie May Manious		4. DATE OF DEATH Month 8 Day 22 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Clearspring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wilkes		14. MOTHER'S MAIDEN NAME Lucy Rockwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Walter Lake		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Atherosclerosis C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 7/6/57, 19, to 8/22/57, 19, that I last saw the deceased alive on 8/22/57, 19, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Searl Young M.D. Hagerstown, Md. 8/25/57 PHYSICIAN'S NAME (Type) SEARL YOUNG M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 8-25-57 22c. NAME OF CEMETERY OR CREMATORY Rose Hill 22d. LOCATION (City, town, or county) (State) Hagerstown Md. 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md. 24a. REC'D BY REGISTRAR Aug. 26. 1957 24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 1 1957

BUREAU V. S.

08920

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>40 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1820 Concord St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Myrtle</b> Last <b>Marshall</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>	11. BIRTHPLACE (State or foreign country) <b>Keedysville Md.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Diner</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Churchey</b>		14. MOTHER'S MAIDEN NAME <b>Irene Kendle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give year or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walter E. Marshall</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Glomerulo Nephritis</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>212x</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 23</b> , 19 <b>53</b> , to <b>Aug 24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 24</b> , 19 <b>57</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hag. Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Philip J. Hirshman</b>		DATE SIGNED <b>8/26/57</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-30-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Benevola E. U. B.</b>	22d. LOCATION (City, town, or county) (State) <b>Benevola Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hag. Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

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08951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN IB <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In auto just out of Hagerstown on Cavetown Pike</b>				d. STREET ADDRESS <b>242 S. Mulberry Street</b>			
3. NAME OF DECEASED (Type or print) <b>EDWARD H MARTIN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1932</b>		9. AGE (In years last birthday) <b>24</b> yrs.	IF UNDER 1 YEAR Months <b>24</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilbur H. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Carrie E. Reynolds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Edward H. Martin</b> <b>242 South Mulberry St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Ruptured, healed dissecting aneurysm of ascending aorta</b> DUE TO (b) <b>Rheumatic valvular heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>none</b>							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-2-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				ADDRESS <b>Wm. C. Host C. Pres</b>		24a. REC'D BY REGISTRAR <b>Aug. 1, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Wm. C. Host</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08952

## CERTIFICATE OF DEATH

Reg. Dist. No.

08941  
304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Rural 1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Rural 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>Rural 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Laveine</u> Last <u>McGusker</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.26.1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Barnhart</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> <u>Rx</u>	
17. INFORMANT <u>Raleigh E McGusker</u>		Address <u>Hancock Rural 1.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atherosclerosis</u> DUE TO <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> 19 <u>55</u> , to <u>Aug 22</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 24</u> 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H E Stabler M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Hancock, Md</u> DATE SIGNED <u>8/23/57</u>	
FURNITURE NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8.24.57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J Stone Hancock Md</u>		24a. REC'D BY REGISTRAR <u>8-24</u> 24b. REGISTRAR'S SIGNATURE <u>J P Keeler</u>	

BUREAU V. S.

MAY 23 1957

RECEIVED

08921

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>FAIRPLAY MD. ROUTE 1</b>			
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>WOODROW</b> Last <b>MOATS</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6 1878</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>TILGHMANTON WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JACOB MOATS</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MORGAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 09 9952</b>		17. INFORMANT <b>MRS. FLORENCE MOATS FAIRPLAY MD. R. 1</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Day</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>10</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/3/57</b> to <b>8/4/57</b> , that I last saw the deceased alive on <b>8/3/57</b> , and that death occurred at <b>10:10</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1115 1st St. N.E. Washington, D.C.</b> DATE SIGNED <b>8/5/57</b>							
ACTUAL SIGNATURE <b>Ralph F. Young M.D.</b>				PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>			
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 7 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MANOR CEMETERY NEAR</b>		22d. LOCATION (City, town, or county) (State) <b>TILGHMANTON WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East View Home Burial Home Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 7, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 9 1957

08953

## CERTIFICATE OF DEATH

08944  
Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b MINUTES	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN ST.		d. STREET ADDRESS ROUTE 40	
3. NAME OF DECEASED (Type or print) JACOB BREWER MUMMA		4. DATE OF DEATH 8 Month 14 Day 19 Year 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1887
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY STATE RD. COMM.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT MUMMA		14. MOTHER'S MAIDEN NAME FRANCES MASTERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-36-3498	
17. INFORMANT MRS. ROBERTA MUMMA		Address HAGERSTOWN RT 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 minute</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 14, 1957, to Aug 14, 1957, that I last saw the deceased alive on Aug 14, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Hedden</u>		DATE SIGNED <u>8/16/57</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Hedden</u>		ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/17/1957	
22c. NAME OF CEMETERY OR CREMATORY GREEN LAWN		22d. LOCATION (City, town, or county) (State) WILLIAMSPORT WASH CO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS CLEAR SPRING, MD.	
24a. REC'D BY REGISTRAR DATE <u>Aug 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Clark</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be re- by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08954

## CERTIFICATE OF DEATH

08945

Reg. Dist. No. 304

1. PLACE OF DEATH a. COUNTY Washington Md MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md. X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Murray		4. DATE OF DEATH Month Day Year 8. 23 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.20.1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 5 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Board		14. MOTHER'S MAIDEN NAME Margarett Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Jesse B Murray Bbg Pool Md.	
17. INFORMANT Address Jesse B Murray Bbg Pool Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1502 Carcinoma of Prostate Gland DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1950 to Aug 25 1957 that I last saw the deceased alive on Aug 22 1957, and that death occurred at M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED H. S. Tabler M.D. H. S. Tabler M.D.			
ACTUAL SIGNATURE NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8.31.57	22c. NAME OF CEMETERY OR CREMATORY Park Head Cemetery	22d. LOCATION (City, town, or county) (State) Rural Big Pool Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Tabler M.D.		24a. RECEIVED BY REGISTRAR DATE 8/31/57	
24b. REGISTRAR'S SIGNATURE J. H. Keller			

BUREAU V. S.

SEP 4 1937

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file this certificate with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. Forward to the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

08922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08946

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE <b>Penna</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockledge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. County Hospital</b>				e. STREET ADDRESS <b>378 Holme Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>RONALD</b> Middle <b>JAMES</b> Last <b>POLIS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1957 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 4 1935</b>		9. AGE (In years last birthday) <b>21</b> yrs.	10. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>Phila Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William A. Polis</b>				14. MOTHER'S MAIDEN NAME <b>Amelia D. Heintz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>William A. Polis</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>822X</b> DUE TO <b>Fractured skull, hemorrhage &amp; shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Entangled with another racing car, on speedway</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:30 a.m. 8-11 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Conecheague</b>		20f. (City or town) <b>Wash.</b> (County) <b>Md.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lawn View Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rockledge Montgomery Co Pa</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md</b>				24a. REC'D BY REGISTRAR <b>Aug 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. J. Brown</b>	

MEDICAL CERTIFICATION

BUREAU

AUG 1 1957

RECEIVED

08923

## CERTIFICATE OF DEATH

08947

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 Mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>419 Mayfair Ave</u>				d. STREET ADDRESS <u>419 Mayfair Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>SUSAN</u> Last <u>PRYOR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30 1898</u>	9. AGE (In years, last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Forrest</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or date of service) <u>314-09-7992</u>		17. INFORMANT <u>Robert R. Pryor</u> Address <u>419 Mayfair Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> <u>1111X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>57</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>57</u> , to <u>Aug 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>57</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>			ADDRESS (Street, city or town, state) <u>318 N. Potomac ST.</u>		DATE SIGNED <u>8-9-57</u>		
PHYSICIAN'S NAME (Type) <u>PAUL HARRISON MD</u>			<u>Hagerstown, MARYLAND</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Zion E.U.B. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Myersville Fred. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 12 1957</u>		
					24b. REGISTRAR'S SIGNATURE <u>Paul H. Bowers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 14 1957

RECEIVED

08924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08948

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>9 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>934 Hamilton Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELL</b> Middle <b>VIOLET</b> Last <b>REED</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 26, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elmer A. Shewbridge</b>		14. MOTHER'S MAIDEN NAME <b>Grace G. Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-4131</b>	
17. INFORMANT <b>Mr. Howard W. Reed</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>1 yr.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> , 1957, to <b>July 7</b> , 1957, that I last saw the deceased alive on <b>July 7</b> , 1957, and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D. <b>214 N. Potomac St.</b> <b>8/7/57</b> PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hall Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>		24a. REC'D BY REGISTRAR <b>Aug 9, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>L. H. Bowers</b>			

BUREAU V. S.

AUG 12 1957

RECEIVED



08949

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		d. STREET ADDRESS 312 West Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 West Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM RANDOLPH REILLY		4. DATE OF DEATH Month Day Year August 24 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3 1865	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days 10 20	IF UNDER 24 HRS Hours Min. 10 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Roads		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Reilly			14. MOTHER'S MAIDEN NAME Mary Ann Rohrer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address Mrs. Emma Katherine Hoover Sharpsburg Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 yrs (?)</u> DUE TO (c) <u>5 yrs (?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 23, 1957</u> to <u>Aug 24, 1957</u> , that I last saw the deceased alive on <u>Aug 23, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>8/25/57</u> ACTUAL SIGNATURE <u>Walter H. Sheehy</u> M.D. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEEHY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Sheehy</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. G. Boyer</u>	

RECEIVED

SEP 4 1957

BUREAU V. S.

08926

## CERTIFICATE OF DEATH

08950

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>24 Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash County Hospital</b>		e. STREET ADDRESS <b>Rockdale</b>	
3. NAME OF DECEASED (Type or print) <b>DANIEL</b> <b>EYSTER</b> <b>ROWE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24 1881</b>
9. AGE (In years lost birthday) <b>76</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Myersville Fred Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josiah Rowe</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Ambrose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-2877</b>	
17. INFORMANT <b>Mrs Barbara A. Rowe Greencastle Pa</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis with Cavitation</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 16, 1957</b> to <b>August 18, 1957</b> , that I last saw the deceased alive on <b>August 18, 1957</b> and that death occurred at <b>10:30 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Maryland</b> <b>Aug. 19, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church of Bretheren Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. REC'D BY REGISTRAR <b>Aug 21 1957</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Blair Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 23 1957

BUREAU V. B.

08927

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Antrim</u>	
c. LENGTH OF STAY IN 1b <u>2 Days</u>		d. STREET ADDRESS <u>RD3 - Greencastle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>F.</u> Middle <u>SHAFER</u> Last		4. DATE OF DEATH <u>August 29</u> Month <u>1957</u> Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Simon Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Miesinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>205-09-6583</u>	
17. INFORMANT <u>Clyde Shaffer</u> Address <u>RD3 Waynesboro, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior - Septate Heart Dis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Failure -</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>27 Aug, 1957</u> to <u>29 Aug 1957</u> , that I last saw the deceased alive on <u>29 Aug 1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul F. Webster</u> M.D.		ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>30 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Welsh Run, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u> ADDRESS <u>Greencastle Pa.</u>		24. REC'D BY REGISTRAR <u>Sept. 3, 1957</u> REGISTRAR'S SIGNATURE <u>W. H. Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
08928					08952				
Item 18: Replacement 3/29/57 G219-L					Reg. Dist. No. 202				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Franklin</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mercersburg</b> <b>7 x</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>					d. STREET ADDRESS <b>117 East Seminary St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY BEAR SHANK</b>					4. DATE OF DEATH Month <b>Aug</b> Day <b>19</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 16 1905</b>		9. AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Martin N. Bear</b>					14. MOTHER'S MAIDEN NAME <b>Lillie Miller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>186-09-5206</b>		17. INFORMANT <b>Martin L. Shank</b> Address <b>117 E. Seminary Ave</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>198x</b> <b>Retroposterior lymphosarcoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8/14, 1957</b> to <b>8/19, 1957</b> , that I last saw the deceased alive on <b>8/18, 1957</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>8:19:57</b>									
ACTUAL SIGNATURE <b>John H. Hornbaker, M.D.</b>					DATE SIGNED <b>8:19:57</b>				
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>					ADDRESS <b>Hagerstown, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethren Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> Address <b>Hagerstown Md.</b>					24a. RECEIVED BY REGISTRAR <b>Aug 29 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. Beverly</b>				

RECEIVED

AUG 29 1957

BUREAU V. E.



### MEDICAL CERTIFICATION

V5 A15 (4)  
15M 9/SS

BUREAU V. S.

AUG 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08954

307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>30 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>339 Elizabeth Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Atlee</b> Middle <b>Barkdoll</b> Last <b>Sheiss</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1916</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Assembler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		11. BIRTHPLACE (State or foreign country) <b>Ringgold Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Barry G. Sheiss</b>				14. MOTHER'S MAIDEN NAME <b>Leah Barkdoll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-4055</b>		17. INFORMANT Address <b>Hagerstown Md.</b> <b>Ruth Rhines Sheiss, 339 Elizabeth Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound into head - 22 calibre</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head with 22 calibre</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>8:30</b> P. M. <b>Aug. 30 19 57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ringgold</b>		22d. LOCATION (City, town, or county) (State) <b>Ringgold, Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Groves, Waplesboro Pa</b>				24a. REC'D BY REGISTRAR <b>SEP 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Powers</b>	

RECEIVED

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

08931

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08955

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>WILLIAM</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>19 57</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/31/1910</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>JANITOR WORK</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES E. SMITH</b>	
14. MOTHER'S MAIDEN NAME <b>BESSIE BAKER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>217-09-9635</b>		17. INFORMANT <b>MR. CECIL SMITH</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 <b>57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, OR OTHER <b>BURIAL</b>		22b. DATE THEREOF <b>8/15/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FAHNEY CHURCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Herment, Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 16, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Frank H. Bowers</b>	

BUREAU V. S.

AUG 19 1957

RECEIVED

08932

CERTIFICATE OF DEATH

08956

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home</b>				e. STREET ADDRESS <b>33 Green Street</b>			
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>HAYS</b> Middle <b>SMITH</b> Last				4. DATE OF DEATH <b>August</b> Month <b>8</b> Day <b>1957</b> Year			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Panama Canal Zone</b>		11. BIRTHPLACE (State or foreign country) <b>Woodbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William Henry Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Liza Noonan</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>213-10-6892</b>				17. INFORMANT Address <b>Mrs. Emma J. Smith Security, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease--2 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>August 7, 1957</b> , to <b>August 8, 1957</b> , that I last saw the deceased alive on <b>August 7, 1957</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>W. J. L. [Signature]</b> M.D. <b>100 Professional Arts Bldg. 2-6-57</b>				PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D. Hagerstown</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suterhouser Funeral Home R. Franklin Roper</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 13 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Shash Powers</b>	

RECEIVED

SEP 15 1904

BUREAU V. S.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08925

## CERTIFICATE OF DEATH

08957

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>13 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>412 Summit Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>ELIZABETH</b> Last <b>SNOOK</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>71</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Tilghmanton Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Turner</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Ridenour</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>214-09-8466</b>		17. INFORMANT <b>Samuel E. Snook 412 Summit Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Five minutes</b> <b>About 3 1/2 yrs.</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown Md.</b>		20g. (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 14, 1959</b> , to <b>Aug 29, 1957</b> , that I last saw the deceased alive on <b>7/5, 1957</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>8:30:57</b>							
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				24. REC'D BY REGISTRAR <b>Sept. 2, 1957</b>			
ADDRESS <b>Hagerstown Md.</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H. H.</b>			

BUREAU V. S.

SEP 4 1957

RECEIVED

08933

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 242 S. Potomac St.		d. STREET ADDRESS 242 S. Potomac St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Thomas Staubs		4. DATE OF DEATH Month Aug. 29, Day 29, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1880
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY tavern	
11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frisby Staubs		14. MOTHER'S MAIDEN NAME Arrabella Grey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-14-5165	
17. INFORMANT Mrs. Irene G. Howen, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/18/57, 19, to 8/29, 1957, that I last saw the deceased alive on 7/30, 1957, and that death occurred at 11:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Jennings		ADDRESS (Street, city or town, state) M.D. 1364 W. Washington St.	
PHYSICIAN'S NAME (Type) George Jennings, M.D.		DATE SIGNED 8/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-31-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Linnich & Son, Hagerstown, Md.		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1957

BUREAU V. S.

08934

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>36 S. POTOMAC ST.</b>		d. STREET ADDRESS <b>36 S. POTOMAC ST.</b>	
3 NAME OF DECEASED (Type or print) First <b>LIZZIE</b> Middle Last <b>STAUFFER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/1866</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9. AGE (In years last birthday) <b>91</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH T. HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY McCauley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>NONE</b>	17. INFORMANT <b>MR. ALVIN P. STAUFFER</b> Address <b>HAGERSTOWN MD.</b>
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED {Enter nature of injury in Part I or Part II of item 18.}	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1</b> , 19 <b>57</b> , to <b>Aug. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 2</b> , 19 <b>57</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>170 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>8/5/57</b>			
ACTUAL SIGNATURE <b>R. S. Stauffer</b>		M.D. <b>170 W. Washington St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. S. Stauffer</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/6/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 7, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 9 1957

BUREAU W. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08960

08935

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>16 1/2 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>Dam # 5 Rd</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER JAMES TIMBERMAN</b>				4. DATE OF DEATH Month Day Year <b>August 27 1957 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 4 1907</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dupont Co</b>		11. BIRTHPLACE (State or foreign country) <b>York York Co Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Parke Timberman</b>			
14. MOTHER'S MAIDEN NAME <b>Janet woodside</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, give war or dates of service) <b>W.W.# 2 147-03-1187</b>			
16. SOCIAL SECURITY NO <b>147-03-1187</b>				17. INFORMANT <b>Mary E. Timberman Big Spring Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Reticulum cell sarcoma of the right lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15</b> , 19 <b>57</b> , to <b>Aug. 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 26</b> , 19 <b>57</b> , and that death occurred at <b>12:40am</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D. Clear Spring, Md. Aug. 27, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem Baptist Cemetery Salem</b>		22d. LOCATION (City, town, or county) (State) <b>Salem Co N. Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 29, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. B. B. B.</b>			

RECEIVED  
SEP 3 1957  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08936

## CERTIFICATE OF DEATH

08961

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland</u>				c. LENGTH OF STAY IN 1b <u>45 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>54 Bloom Alley</u>			
3. NAME OF DECEASED (Type or print) <u>Theodore</u> First <u>(no)</u> Middle <u>Timbers</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 16 1903</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Lovettsville Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Joseph Timbers</u>				14. MOTHER'S MAIDEN NAME <u>Lea Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Gertrude William</u> Address <u>140 W. Bethel St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epithelial carcinoma esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>028 Lues, late latent</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>57</u> , to <u>August 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>57</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>100 Pto Condonal Aris Bldg</u> <u>8-9-57</u> PHYSICIAN'S NAME (Type) <u>William T. Langan, M.D.</u> <u>Hagerstown Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 10 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr. Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1 HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08937

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08962  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md RFD 1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Pinesburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mammie</b> Middle <b>Mae</b> Last <b>Timmons</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1935</b>		9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Dennis Grams</b>				14. MOTHER'S MAIDEN NAME <b>Mrs. Mammie Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>217-30-6153</b>		17. INFORMANT <b>Mr. Leroy D Timmons</b> Address <b>Williamsport Md RFD1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured(open) rt. tibia</b> DUE TO <b>Fractured ribs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emboli (acute)</b> DUE TO <b>Delayed hemorrhage into spleen</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>14 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident</b>					
20c. TIME OF INJURY Hour <b>10:35</b> AM Month, Day, Year <b>Aug. 16 '57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>Aug. 31 '57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. Thompson, Jr.</b> ADDRESS <b>Williamsport, Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 31, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowser</b>	

MEDICAL CERTIFICATION

21

1057

1057

RECEIVED

08938

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				e. STREET ADDRESS <u>303 Bryan Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET CAROLINE WARNER</u>				4. DATE OF DEATH Month Day Year <u>August 24 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md Hagerstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Klipp</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Angle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harry B. Warner Sr</u> Address <u>303 Bryan Place</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Recto-Sigmoid</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 27</u> , 1957, to <u>Aug 24</u> , 1957, that I last saw the deceased alive on <u>Aug 24</u> , 1957, and that death occurred at <u>11:12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert P. Conrad</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>		DATE SIGNED <u>8-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				<u>137 W. Washington</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 28 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert P. Conrad</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 30 1957

RECEIVED

C8939

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEAVER CREEK RURAL (CRESHEIM)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE ECCARD WEAGLY</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 16 1957 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 8 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BEAVER CREEK WASH.CO.MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NATHAN C. ECCARD</b>				14. MOTHER'S MAIDEN NAME <b>CHARLOTTE R. GAVER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>ROY C.F. WEAGLY HAGERSTOWN MD. ROUTE 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Histiosischoctic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Coronary Insufficiency</b> DUE TO (c) <b>Chronic interstitial cystitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>	
PART II. OTHER DISEASES OR CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic interstitial cystitis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Aug 15, 1957</b> to <b>Aug 16, 1957</b> , that I last saw the deceased alive on <b>Aug 15, 1957</b> and that death occurred at <b>10:30</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Edward W. Dittus, M.D. 212 W. Washington, You St 8/16/57</b>							
ACTUAL SIGNATURE <b>Edward W. Dittus, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Edward W. Dittus, M.D. Hagerstown, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>AUG. 18 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CREEK CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BEAVER CREEK WASH.CO.MD.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR <b>Aug 22, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>East Hagerstown</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
AUG 22 1957  
BUREAU Y. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08965

08940

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>33 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>633 S. POTOMAC ST.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NORMAN EVANS WEST SR.</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 14 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/1/1908</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOP SUPT.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO.</b>			
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>JOHN F. WEST</b>				14. MOTHER'S MAIDEN NAME <b>RUIE EVANS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-1152</b>			
17. INFORMANT <b>MRS. EVELYN N. WEST</b> Address <b>HAGERSTOWN MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis of the coronary artery</b> <b>420.1</b> DUE TO <b>with occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Aug. 14</b> , 19 <b>57</b> , to <b>Aug. 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 14</b> , 19 <b>57</b> , and that death occurred at <b>8:35 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Md.</b> DATE SIGNED <b>8/15/57</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>8/16/57</b>		<b>REST HAVEN CEM.</b>		<b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>Aug. 16, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

RECEIVED

AUG 19 1957

BUREAU V. 2

or death: Page 4

2 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death by the hospital or attending physician.

the funeral director should be filed with

ECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be detached for use as the burial-transit permit, and in any event within 72 hours after death.

TO HOSP.

may be 1

TO FUNER.

page 3 should

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 14  
15M 9/55

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08941

## CERTIFICATE OF DEATH

Reg. Dist. No.

08966 ✓

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Josiah</b> Last <b>Wilhide</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-1903</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.	IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry W. Wilhide</b>	
14. MOTHER'S MAIDEN NAME <b>Clara K. Damuth</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>219-36-4852</b>		17. INFORMANT <b>Mrs. Ruth B. Wilhide</b> Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma.</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary carcinoma of stomach.</b> DUE TO (c) <b>4 mo.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. 91.</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>57</b> , to <b>8/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/13</b> , 19 <b>57</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Maryland</b> DATE SIGNED <b>8/15/57</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b>		M.D. <b>Smithsburg, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-16-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Maryland</b>	
24a. RECEIVED BY REGISTRAR <b>Aug 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Lowrey</b>	

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Married \_\_\_\_\_

Place of death \_\_\_\_\_

Name of decedent \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

White \_\_\_\_\_

Other \_\_\_\_\_

Place of birth \_\_\_\_\_

Occupation \_\_\_\_\_

Married \_\_\_\_\_

Name of decedent \_\_\_\_\_

Name of decedent \_\_\_\_\_

Name of decedent \_\_\_\_\_

Sex \_\_\_\_\_

BUREAU Y. 3

AUG 16 1957

RECEIVED

Department of Health

United States

State of \_\_\_\_\_

Department of Health

State of \_\_\_\_\_